ROLLA REGIONAL CENTER FOR THE
DEVELOPMENTALLY DISABLED
105 Fairground Road
Rolla, Missouri

CLIENT SEIZURE RECORD

CLIENT NAME: _____

PLACEMENT FACILITY: _____

DATE	TIME	LENGTH OF SEIZURE (Time)	DESCRIPTION OF SEIZURE	ACTION TAKEN	CLIENT MEDICATION

SIGNED: _____

Community Agency - Complete and give to Case Manager
Retain copy in facility client file

Case Manager - Copy to Client Record
Copy to Medical Personnel

Client Records - Fine in Client Master File, Medical